

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010235</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/22/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>HARBOUR ASSISTED LIVING OF FORT WAYNE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3110 E COLISEUM BLVD FORT WAYNE, IN 46805</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Date: October 22, 2012</p> <p>Facility number: 010235 Provider number: 010235 AIM number: N/A</p> <p>Survey team: Angela Strass, RN-TC Rick Blain, RN Sue Brooker, RD Diane Nilson, RN</p> <p>Census bed type: Residential: 58 Total: 58</p> <p>Census payor type: Other: 58 Total: 58</p> <p>Sample: 7</p> <p>Harbour Assisted Living of Fort Wayne was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed on October 23, 2012 by Bev Faulkner, RN</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1